Neville Service Ltd (Trading as Nu Cosmetic Clinic Liverpool)

Neville Service

Inspection report

33a Rodney Street
Liverpool
Merseyside
L1 9EH
Tel: 01517079239
Website: www.nevilleserviceclinic.com

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Overall summary

We carried out an unannounced focussed inspection on 5 November 2015, due to concerns raised from service users about the quality and safety of the service provided. We looked at whether the service was safe, effective and well-led.

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

Background

Neville Service (trading as Nu Cosmetic Clinic Liverpool) is an independent healthcare provider situated in Rodney Street Liverpool and provides cosmetic surgery. The clinic is open 9am to 5.30pm Monday to Friday and also provides weekend appointments.

The responsible individual for the registered provider is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our inspection identified there was a serious risk to patients' lives, health or wellbeing. As a result of serious concerns being identified on 5 November 2015 the registration of this provider was cancelled with immediate effect by court order on 25 November 2015 under section 30 of the Health and Social Care Act 2008.

Our key findings were:

- The service did not identify record or investigate significant or serious incidents that had occurred.
- There was no system in place to learn from incidents to reduce the risk of harm to patients.
- Staff demonstrated no understanding of incident reporting to improve the safety of the service provided.
- The system in place to record patients medical histories prior to a procedure taking place were inadequate and placed patients at risk of harm.

Summary of findings

- There was no infection control policy and procedure in place to protect patients from healthcare associated infections.
- The recruitment process in place was inadequate and there was no appraisal system in place. This placed patients at risk of receiving unsafe and inappropriate care and treatment.
- Complaints were not appropriately investigated or handled in an open and transparent manner.
- Patients' records were poorly maintained.
- Patients' informed consent was not routinely sought.
- There were no clinical governance systems in place to monitor the safety of the service.
- Emergency equipment and medicines available at the service were not adequate to maintain patient safety with regard to some of the surgical procedures being carried out.
- The registered manager had insufficient knowledge of his role and responsibilities to maintain a safe environment for patients to receive care and treatment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

The service did not recognise unsafe care and treatment and there were no systems in place to mitigate risks to patients. We looked at a total of eight patient records and three in detail. We found that there had been two significant incidents in August and October 2015 that required analysis to determine what lesson could be learned to minimise the risk of these types of incidents occurring again.

The staff recruitment system was unsafe. For example we asked the registered manager for the recruitment records for all staff employed by the service. The registered manager was not able to provide recruitment records for 15 people detailed in the operating log book including five doctors. The lack of recruitment records and oversight of the people working at the service left patients at risk of significant harm.

There was no system in place to review the quality and safety of the work carried out by clinicians.

There was no infection control policy and procedures to ensure the clinical areas were hygienically clean and minimise the risk of infection.

Emergency equipment and medicines available at the service were not adequate to maintain patient safety with regard to some of the surgical procedures being carried out.

The service did not carry out or request maintenance and safety checks for equipment brought by clinician to treat patients.

The service did not have an operating theatre procedure in place.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Patients' medical histories in the form of a pre-operative assessment were recorded. However, records showed that when an issue had been identified, for example episodes of depression and anxiety and undergoing medical investigations such as an ECG (An electrocardiogram is a test that checks for problems with the electrical activity of your heart), this information was not acted upon to ensure the proposed surgical procedure was safe or appropriate. This lack of clinical review of medical information had resulted in harm to patients.

Patient records showed that the service did not routinely seek information from patients' GPs to ensure the surgical procedures to be undertaken were safe to be carried out.

Records showed that patients' informed consent was not routinely sought and that patients were not supported to take a cooling off period or offered a second opinion prior to the surgical procedure taking place.

There was no training record in place to determine if staff had the necessary skills and competencies to carry out the treatments and care provided by the service.

Are services caring?

Are services responsive to people's needs?

Summary of findings

Are services well-led?

We the service was not providing well-led care in accordance with the relevant regulations.

The service had no clinical governance systems (clinical governance is a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish). The service did not carry out audits to ensure that clinicians working at the service were providing safe and effective care and were given the opportunity to identify opportunities to improve their practice and outcomes for patients.

There was no system in place to monitor outcomes of intervention including holding clinicians to account for their clinical decisions. There was no system in place to support peer review and enable shared learning.

Meetings between the registered manager, clinicians and other staff working at the service did not take place. There were no systems in place to enable effective communication to promote the safety of patients.

Complaints were not managed in an open and transparent manner.

The registered manager demonstrated no understanding of the service being provided and the legal roles and responsibilities of a registered manager to meet the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service must be run.

Neville Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out due to concerns raised with CQC about the safety and quality of the service provided. A focussed unannounced inspection took place to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 5 November 2015 and was conducted by a CQC inspector, a CQC inspection manager, a clinical specialist advisor and a clinical governance specialist advisor. The inspection team spoke to staff, reviewed patient records and the service's policies and procedures.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We asked the registered manager for the significant events audit/log. The registered manager did not appear to understand what we were asking to see. We explained that significant event analysis is a way of formally analysing incidents that may have implications for patient safety and care, learning from what went wrong or right should improve the safety and quality of the service provided to patients. The registered manager told us such incidents did not take place so they did not keep this type of record.

We viewed three patient records in detail and found that on three separate occasions incidents had occurred that posed a significant risk to patients. For example, a procedure was stopped due to medical complications and a procedure was carried out in an inadequate operating theatre. The registered manager did not view these incidents as significant, no analysis had taken place and therefore no learning had been identified and shared to reduce the risk of similar incidents happening again. The lack of a system to identify and act on significant events left patients at risk of significant harm.

Reliable safety systems and processes (including safeguarding)

There was no system in place to monitor the skills, qualifications and competencies of the people who worked at the service. For example, we asked the registered manager for the recruitment records of all clinicians who were recorded in the theatre logbook. The registered manager was unable to provide the records for five clinicians who were identified as carrying out or being directly involved surgical procedures on patients. The lack of a robust system to monitor the skills, qualifications and competencies of people who worked at the service left patients at significant risk of harm.

Patient records showed that informed consent was not routinely sought. For example, a patient had a procedure carried out and had signed their consent. However, the consent form provided information about a different procedure. A further example was that a patient provided consent for a number of procedures at the same time. However, some were not performed for several months, yet this document was not revisited with the patient prior to the surgical procedure being carried out.

We asked the registered manager to provide the policies and procedures that governed the regulated activities of surgical procedures, treatment of disease disorder and injury and diagnostic and screening. The registered manager provided no policies that detailed how the service managed patients care, treatment and welfare. For example, there was no protocol in place for the use of the minor surgery operating theatre. There were no protocols in place with regard to how the pre-operative form was to be completed and action to be taken if information of concern was identified.

We asked the registered manager for the operating theatre procedure. The registered manager told us that they did not have one as each clinician decided how they liked to work. The lack of a standardised operating theatre procedure left patients at risk of significant harm.

Medical emergencies

A patient record identified that sedation had been used in a complex surgical procedure, records showed that an anaesthetist had been present. However, the emergency equipment and drugs provided by the service were not adequate to deal with a medical emergency that may occur due to the use of sedation and the type of surgery being undertaken. We asked the registered manager about this and he told us the anaesthetist brought their own equipment, drugs and operating department practitioner (OPD). We asked to see the records that demonstrated that the equipment used by the anaesthetist had been appropriately maintained. We also asked to see the recruitment records for the anaesthetist and the OPD to confirm they were appropriately qualified and competent. The registered manager did not provide any recruitment records. This left patients at significant risk of harm.

Staffing

The service offered clinician practising privileges to work at the service. However, they did not carry out robust checks to ensure clinicians had the necessary skills and competencies to carry out the surgical procedures being provided. The registered manager did not provide recruitment checks for five clinicians whose names were documented in the theatre operating record as carrying out surgical procedures. The lack of a recruitment and monitoring system of people who provided invasive surgical treatments at the service left patients at significant risk of harm.

Are services safe?

The staff recruitment system in place was unsafe. For example, we asked for the recruitment records for all staff employed by the service. The registered manager was unable to tell us who was employed by the service. We noted that on the service's theatre operating records, 12 first names were recorded as being involved in providing care and treatment to patients that the manager was unable to provide staff recruitment records for. The lack of an effective and safe recruitment system left patients at significant risk of harm.

Monitoring health & safety and responding to risks

The service did not monitor risks to patients not carried out a risk assessment in regard to a clinician who had condition and a warning attached to their General Medical Council (GMC) registration.

The service did not have a training record and recruitment records for 16 people who worked at the service. There was no evidence they had received basic life support training.

Emergency equipment and medicines available at the service were not adequate to maintain patient safety with regard to some of the surgical procedures being carried out.

Infection control

There was no infection control policy and procedures such as cleaning schedules to ensure the clinical areas were hygienically clean. There was no system in place to monitor outcomes of intervention including post – operative infection rates. Clinical areas of the service were found to be dirty with debris on floors and work surfaces and the flooring in one clinical area was dirty. The registered manager demonstrated no understanding of the need to maintain a hygienically clean environment to minimise the risk of healthcare associated infections.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

Patients' medical histories in the form of a pre-operative assessment were recorded. However, records showed that when an issue had been identified for example episodes of depression and anxiety and undergoing medical investigations such as an ECG (An electrocardiogram is a test that checks for problems with the electrical activity of your heart), this information was not acted upon to ensure the proposed surgical procedure was safe or appropriate. This lack of clinical review of medical information had resulted in potential harm to patients.

Staff training and experience

We asked the registered manager to provide the recruitment and training records for all staff who worked at the service. The manager did not provide the training or recruitment records for four clinicians who were documented in the theatre operating records as carrying out surgical procedures and twelve other staff who were recorded as supporting clinicians in providing care and treatment to patients.

Working with other services

Patient records showed that the service did not routinely seek information from patients GPs to ensure the surgical procedures to be undertaken were safe to be carried out. Records showed that on one occasion a patient's GP questioned the appropriateness of a proposed surgical procedure. There was no evidence that the clinician discussed this issue with the patient or sought further information from the GP.

Consent to care and treatment

Records showed that patients' informed consent was not routinely sought and that patients were not supported to take a cooling off period or offered a second opinion prior to the surgical procedure taking place. The information provided to patients prior to surgery and following surgery were inadequate and on one occasion did not relate to the procedure that had been carried out.

Are services caring?

Our findings

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Governance arrangements

The service had no clinical governance systems (clinical governance is a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish). The service did not have a clinical governance lead and there was no oversight of the operation of the service. For example, there were no policies and procedure in place to govern activities such as infection control, recruitment, theatre operating procedures. The service did not carry out clinical audits to ensure that clinicians working at the service were providing safe and effective care and treatment and were given the opportunity to identify opportunities to improve their practice and outcomes for patients.

The service did not recognise unsafe care and treatment and there were no systems in place to mitigate risks to patients.

There was no evidence that the service monitored the training needs of the staff providing care and treatment to ensure they had the necessary skills and competencies to provide safe care and treatment.

There was no system in place to monitor outcomes of intervention including holding clinicians to account for their clinical decisions. There was no system in place to support peer review and enable shared learning.

Leadership, openness and transparency

Complaints were not managed in an open and transparent manner. The manager told us that if they had refunded the cost of the treatment to a patient who was not happy with the treatment provided, he did not consider this to be a complaint that required any further action. Complaint records showed that complaints were not investigated and there was no process in place to learn lessons and to review systems to improve the safety and quality of the service provided.

The registered manager had no oversight of the service and had no systems in place to monitor how effect and safe the care and treatment of patients. The registered manager demonstrated no understanding of the legal roles and responsibilities of a registered manager to meet the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service must be run.

Learning and improvement

There was no system in place to determine that the service was aware of best practice guidance in relation to the care and treatment provided to patients.

The service did not monitor the training needs of staff and were unable to demonstrate the staff had the necessary skills and competencies to provide safe and effective care and treatment.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Patients were not protected from the significant risk of unsafe care and treatment.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Patients were not protected against the significant risk of harm due to the lack of governance systems to monitor the safety of the service provided.**